Reset

EQ05

DO NOT USE THIS SPACE

Employee's Request for Administrative Conference
Minn. Stat. § 176.239, subd. 2

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
INSURER CLAIM NUMBER	INSURER/SELF-INSURER/TPA

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE

1. BOX (check one) 1 ☐ 2 ☐ 3 ☐ is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.
2. My weekly benefits should not be changed/stopped because: _____

(attach separate sheet if more room is needed)

EMPLOYEE SIGNATURE	EMPLOYEE PHONE # (include area code)	DATE
ATTORNEY (if you have one) ATTORNEY #	ATTORNEY PHONE # (include area code)	QRC (if you have one)